Domestic Violence and Abuse Protocol

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The April 2013 Government definition of domestic violence and abuse is:

Any incident or pattern of incidents of **controlling, coercive or threatening behaviour, violence or abuse** between those aged **16 or over** who are or have been **intimate partners or family members regardless of gender or sexuality**. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional.

Definition continued..

- **Controlling behaviour** is: acts designed to make a person **subordinate** and/or **dependent** by **isolating** them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and **regulating** their everyday behaviour.

- **Coercive behaviour** is: an act or a pattern of acts of assault, threats, **humiliation and intimidation** or other abuse that is used to harm, **punish**, or **frighten** their victim.'

- Includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group

April 2013

The need for a policy

- It is a big and growing problem – nationally, in the next week at least 30,000 women will experience domestic violence and two of them will be murdered. Over 30,000 children will be in a DV hostel.
- Our services users are at increased risk,
- Staff are unsure what to do and report it as an increasing problem,
- Staff need to be supported to assess, respond and refer safely,
- It is a difficult situation to address as a professional- particularly as 1:4 women and 1:6 men are victims in their lifetime.

Diversity

- DV does not discriminate and happens in **all groups and sections of society** regardless of race, gender, disability, age, culture, mental health, religion, socio-economic level or sexual orientation
- **Culture** may have an **impact on how the DV is experienced, dealt with and responded to**

Gender

- DV responsible for more ill health and premature death in females under 45 than any other well known risk factor such as high BP, obesity and smoking (VicHealth, 2004)
- 89% of people who suffer 4 or more domestic violence assaults lifetime are women
- Over 50% of female homicides committed by current or ex-partner (Krug E et al, 2002)

Health impacts – mental health

	Odds ratio
depression: 18 studies	3.8
PTS: 11 studies	3.7
alcohol abuse: 9 studies	5.6
Suicidal ideation: 13 studies	3.6

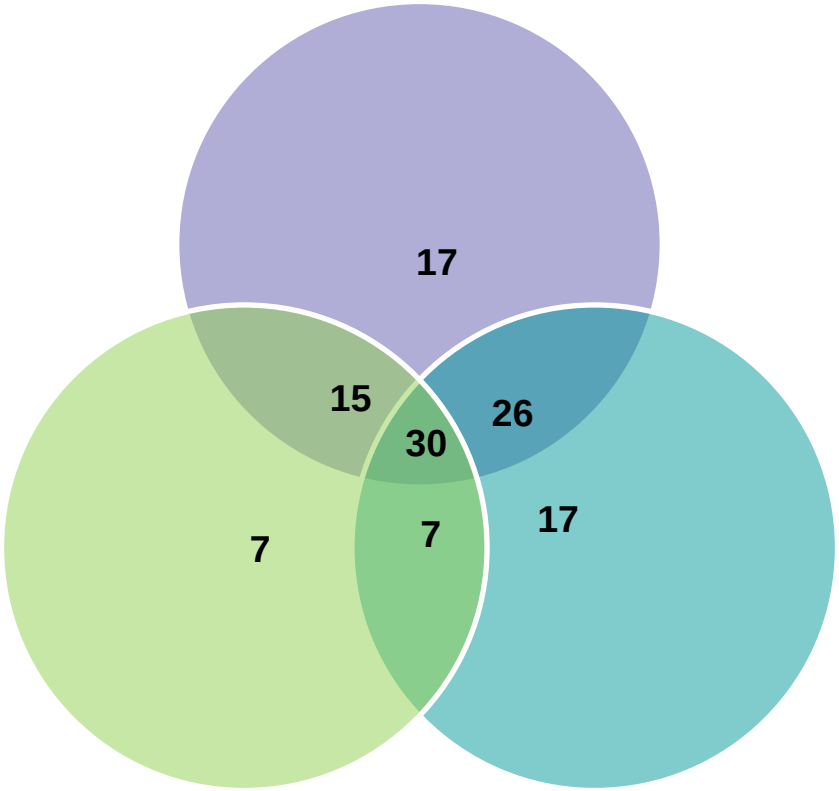
(Golding, 1999, Meta-analysis of domestic abuse and mental health)

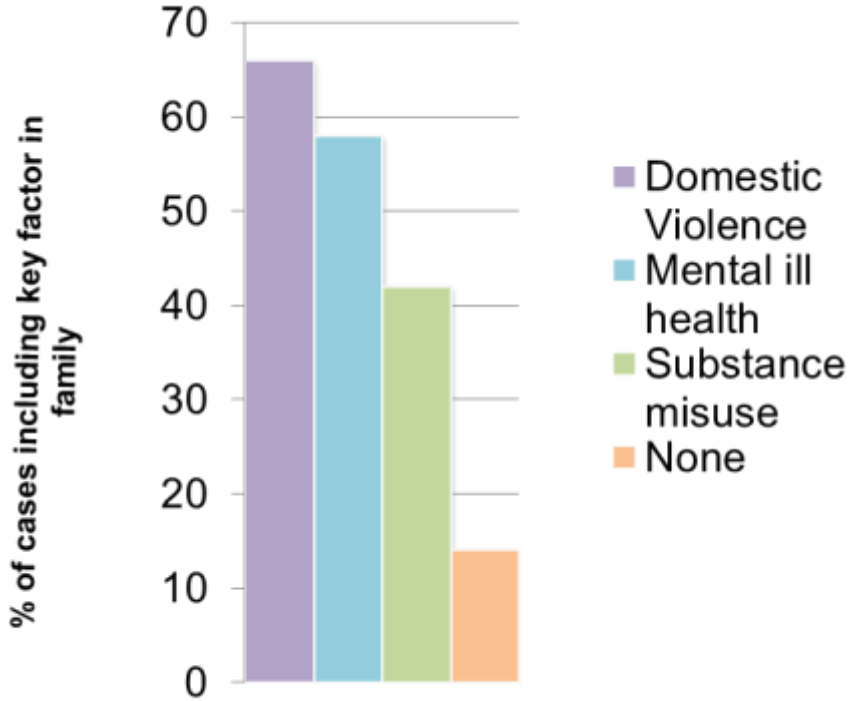
Links between Domestic Violence and Child Abuse

- The risks to children living with DV include direct physical or sexual abuse of the child. Research shows that this happens in up to 60% of cases and that the severity of the violence against the mother is predictive of the severity of abuse to the children
- **Witnessing violence is a risk factor for psychological disorders in children & young people, educational problems and risk taking behaviour** (ESRC violence research programme 2002)
- Adoption & Children Act 2002 definition of harm "including, for example, impairment suffered from seeing or hearing the ill treatment of another"
- **Nearly 75% of children subject of a CP plan lived in households where DV occurs**

DV links clearly seen in the children who were the subjects of children subject to a serious case review 2010-11

Number of families where domestic abuse, mental ill health or substance misuse existed (Out of a total of 139)





86% of the children lived in an environment where one or more of these factors was present, and for 30 children (22%) all three factors co-existed. Any two of the three characteristics were present in 48 families (35%) and a single characteristic in 41 families (29%). While, singly, parental substance misuse, domestic violence and parental mental ill health may pose risks of harm to the child, it is the combination of these factors which is particularly 'toxic'. The existence of these characteristics is not a given in all cases - in twenty reviews (14%) none of these features were indicated. (DfE 2012)

BEH Domestic Violence and Abuse Policy 2013

To support staff in responding to DV

- To recognise
- To respond
- To refer

Domestic Violence Fact Sheet and Pathway for Barnet May 2013

What is domestic abuse?

- Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.
- The behaviour is intentional and is calculated to induce fear and misuse power to control how the victim thinks, feels and behaves.
- Can be psychological, physical, sexual, financial or emotional and includes 'honour' based violence, female genital mutilation and forced marriage.

Every social group and one in four women and one in six men are likely to experience domestic abuse at some time during their life.

Who is at increased risk?

- Women and teenage girls
- Adults who are vulnerable or "At risk"
- Escalation of violence may start or increase during pregnancy
- Individuals suffering with mental ill health, physical disability, learning disability, substance misuse.
- **Women are at greater risk of violence, or even death, around the time of separation from a perpetrator**

There may be indicators of domestic abuse, the victim or perpetrator may disclose it or you may be informed by another professional. If not:

What to ask about domestic abuse

- It is a good idea to ask all women and those at increased risk if they are victims of DV. This can be done as part of your usual assessment process and recorded with a risk assessment. Some may also want help as perpetrators.
- **NEVER ask a women when her partner is present**

Suggested questions to ask as selective or routine enquiry:

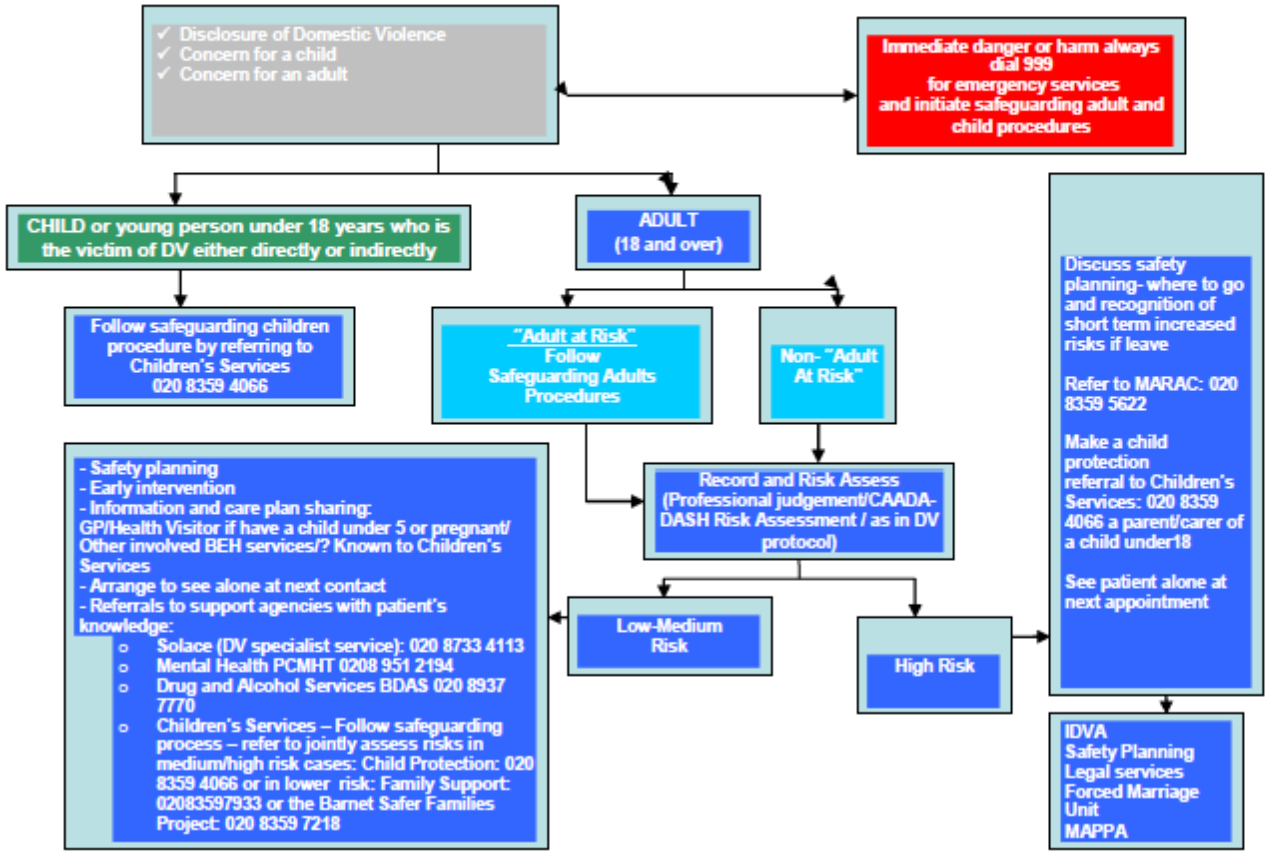
- I don't know if this is a problem for you, but we are asking all women/patients/service users if they experience any problem with their partners, because it can be hard to ask for help?
- Are you experiencing any violence or any violence between you and your partner?
- Does your partner ever hit you or control you in any other way?

How to respond

- Listen and assess risks to the victim and any children.
- Use the risk assessment in the protocol if you want to assess the risk
- Record what you see and are told accurately but never include in reports or letters sent to the home
- Children are likely to be at considerable emotional and physical risk even if they were not present in the room
- Think about who to refer to – use the chart over the page. Never advise the victim to leave without specialist support

Domestic Violence Fact Sheet and Pathway for Barnet May 2013

Domestic Violence Pathway BEH-MHT Barnet



Recognition -who is at increased risk?

- Women and teenage girls
- Adults, **male or female** who are vulnerable or “At risk”
- Pregnant women - frequently violence starts or increases during **pregnancy**
- Individuals suffering with **mental ill health**, physical disability, **learning disability**, **substance misuse**.
- Women are at **greater risk** of violence, or even death, around **the time of separation from a perpetrator**

How we recognise and assess DV risk

- As part of every standard assessment process in all services
- With the knowledge that every professional intervention can potentially increase risks to the victim and any child
- By thinking about what we already know- indicators of domestic abuse, the victim or perpetrator's disclosure or information from another professional.

Asking the question

Ask as part of usual assessment processes and recorded within the risk assessment.

Ask all women, and men who may have a problem that makes them more **at risk** (such as mental ill health, physical disability, learning disability or substance misuse), if they are victims of DV.

NEVER ask a women **when her partner is present** and never document it in letters to the home address. **Be aware of related interpreters.**

Example questions:

- I don't know if this is a problem for you, but we are asking all women/patients/service users if they experience any problem with their partners, because it can be hard to ask for help?
- **Are you experiencing any violence or any violence between you and your partner?**
- **Does your partner ever hit you or control you in any other way?**
- Are you having any problems with your husband/partner/anyone at home? Has someone hurt you?
- **Are you afraid of anyone at home? Does anyone try to control you or what you do**?

Response to a disclosure or assessment that DV is present

Key messages (verbal and non-verbal)

- I believe you
- It's not your fault
- Support is available
- Thank you for telling me
- Everyone has the right to be safe at home

Don't expect disclosure- victims are scared

Assess risk

When considering risk

There are risk assessments to guide staff within the the policy but it is important that professional judgement is used:

- How worrying is the abuse history?
- Is the abuse becoming more frequent, intense or severe?
- Is the abuser using or threatening to use a weapon?
- Has the abuser threatened to kill her or any one else?
- Has there been any attempted strangulation?
- Is the mother pregnant or has she recently had a child?
- Is separation being considered?
- Is there any forced participation in court ordered child contact?

Risk Assessment cannot be wholly accurate nor infallible and **cannot be used to predict whether or not an event will happen.**

It needs to be repeated as risk and partners change. With a change in partner risk may increase.

Assess immediate risk

- Is it safe for you to go home?
- What are you afraid might happen?
- What has the abuser threatened?
- What about threats to the children?

- Consider safety planning but this would usually involve another agency

Referral

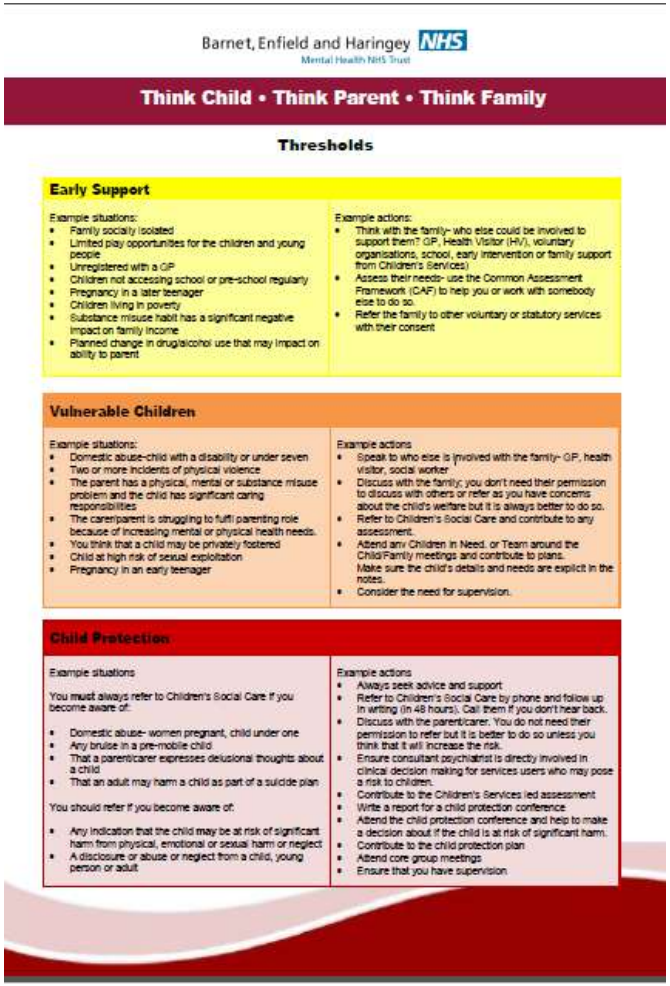
- Domestic Violence Support- refer, give number and support them to access
- If an “adults at risk” use safeguarding adults procedure
- If children in family and risk is medium or above refer to Children’s Services (If the victim is pregnant or there is a child under one in the family you must refer).
- If the risk is medium/high consider referral to MARAC.

Multi Agency Risk Assessment Conference (MARAC)

- MARACs are meetings where information on high risk domestic abuse victims is shared between local public agencies. Aims to share information and produce a coordinated safety plan to support the victim.
- There are MARAC meetings in each borough every 3-4 weeks where around 20 cases are discussed.

The perpetrator should not be informed about a MARAC

Threshold guidance



Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Think Child • Think Parent • Think Family

Thresholds

Early Support

Example situations:
- Family socially isolated
- Limited play opportunities for the children and young people
- Unregistered with a GP
- Children not accessing school or pre-school regularly
- Pregnancy in a later teenager
- Children living in poverty
- Substance misuse habit has a significant negative impact on family income
- Planned change in drug/alcohol use that may impact on ability to parent

Example actions:
- Think with the family- who else could be involved to support them? GP, Health Visitor (HV), voluntary organisations, school, early intervention or family support from Children's Services)
- Assess their needs- use the Common Assessment Framework (CAF) to help you or work with somebody else to do so.
- Refer the family to other voluntary or statutory services with their consent

Vulnerable Children

Example situations:
- Domestic abuse-child with a disability or under seven
- Two or more incidents of physical violence
- The parent has a physical, mental or substance misuse problem and the child has significant caring responsibilities
- The carer/parent is struggling to fulfil parenting role because of increasing mental or physical health needs.
- You think that a child may be privately fostered
- Child at high risk of sexual exploitation
- Pregnancy in an early teenager

Example actions
- Speak to who else is involved with the family- GP, health visitor, social worker
- Discuss with the family; you don't need their permission to discuss with others or refer as you have concerns about the child's welfare but it is always better to do so.
- Refer to Children's Social Care and contribute to any assessment.
- Attend any Children in Need, or Team around the Child/Family meetings and contribute to plans. Make sure the child's details and needs are explicit in the notes.
- Consider the need for supervision.

Child Protection

Example situations

You must always refer to Children's Social Care if you become aware of:
- Domestic abuse- women pregnant, child under one
- Any bruise in a pre-mobile child
- That a parent/carer expresses delusional thoughts about a child
- That an adult may harm a child as part of a suicide plan

You should refer if you become aware of:
- Any indication that the child may be at risk of significant harm from physical, emotional or sexual harm or neglect
- A disclosure or abuse or neglect from a child, young person or adult

Example actions
- Always seek advice and support
- Refer to Children's Social Care by phone and follow up in writing (in 48 hours). Call them if you don't hear back.
- Discuss with the parent/carer. You do not need their permission to refer but it is better to do so unless you think that it will increase the risk.
- Ensure consultant psychiatrist is directly involved in clinical decision making for services users who may pose a risk to children.
- Contribute to the Children's Services led assessment
- Write a report for a child protection conference
- Attend the child protection conference and help to make a decision about if the child is at risk of significant harm.
- Contribute to the child protection plan
- Attend core group meetings
- Ensure that you have supervision

Perpetrator presentation

- **Predominantly male**
- Help-seeking strategies include presenting as “victim” mainly to health agencies, mostly GPs, seeking counselling or other therapeutic-type services
- **Complete denial**
- **Forgetting, blanking out and not knowing**
  "It all happened a bit quick", "I can't really remember" or "I don't know what we were arguing about". This is often an attempt to obscure his violence and its meaning both from himself and from others.

Perpetrators are our patients too

Possible questions you can ask patients

- How are things at home?
- Are you stressed?
- What do you do when you become stressed or angry?
- Does your behaviour scare you/your family/children?
- Does your behaviour make you/family/children sad?
- Do you feel out of control?

Risk assess and refer using same criteria as victims

Regan, L 'If only we'd known', 2007; Strength to Change, Hull, 2011; Domestic Violence Intervention Project

Last year we just existed ...
.... this year we are living

My partner was a difficult man. It was hard to know where I was with him. One minute he was lovely, the next furious about something. My actions seemed to upset him so much. The way I dressed, the way I kept the house. Some days everything I did was wrong. He made me feel it was me. I felt entirely responsible for him and I tried to change. I relied on the good days to keep us together but the bad days became more frequent, especially after our daughter was born. The constant worry about the consequences if he got angry took over and dominated our lives.

I felt dependent on him for everything but my life was becoming unmanageable. My daughter was obviously affected by his angry outbursts. I couldn't make excuses for his abusive behaviour anymore. I couldn't think how to make my life different. I didn't know what to do. But I spoke to people who understood. They helped me make a plan to keep safe and take control of my situation.

Now I decide how I spend my money, when I go to bed, how long I take shopping, who I talk to and when. I open my own post and answer the phone. Looking back I can't believe what I mistook for love. It's not been easy but I have rediscovered life.